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105TH CONGRESS
1ST SESSION

H. R. 1415

To amend the Public Health Service Act and the Employee Retirement Income Security Act of 1974 to establish standards for relationships between group health plans and health insurance issuers with enrollees, health professionals, and providers.

IN THE HOUSE OF REPRESENTATIVES

APRIL 23, 1997

Mr. NORWOOD (for himself, Mr. BACHUS, Mr. BAKER, Mr. BARCIA, Mr. BARR of Georgia, Mr. BARRETT of Wisconsin, Mr. BISHOP, Mr. BROWN of Ohio, Mr. CANADY of Florida, Mr. CHAMBLISS, Mr. COBLE, Mr. COBURN, Mr. COMBEST, Mr. COOKSEY, Mr. CRAMER, Mr. DAVIS of Illinois, Mr. DAVIS of Virginia, Mr. DEAL of Georgia, Mr. DEFAZIO, Mr. DICKEY, Mr. DUNCAN, Mr. FILNER, Mr. FOLEY, Mr. FOX of Pennsylvania, Mr. FROST, Mr. GILMAN, Mr. GRAHAM, Mr. HALL of Ohio, Mr. HILLEARY, Mr. HILLIARD, Mr. HINCHEY, Mr. JENKINS, Mrs. KELLY, Mr. KENNEDY of Rhode Island, Mr. KIND, Mr. LAHOOD, Mr. LEWIS of Kentucky, Mr. LINDER, Mr. LIVINGSTON, Mrs. MALONEY of New York, Mr. MCHALE, Mr. MCHUGH, Mrs. MORELLA, Mrs. MYRICK, Mr. NETHERCUTT, Mr. PALLONE, Mr. PICKERING, Mr. RANGEL, Mr. RIGGS, Mrs. ROUKEMA, Mr. SANDERS, Mr. SCARBOROUGH, Mr. SENSENBRENNER, Mr. SHADEGG, Mr. SOLOMON, Mr. SPENCE, Mr. STRICKLAND, Mr. TOWNS, Mr. WALSH, Mr. WICKER, Mr. WISE, Ms. WOOLSEY, Mr. WEYGAND, Mr. CHRISTENSEN, Mr. COLLINS, and Mr. WAMP) introduced the following bill; which was referred to the Committee on Commerce, and in addition to the Committee on Education and the Workforce, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

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A BILL

To amend the Public Health Service Act and the Employee Retirement Income Security Act of 1974 to establish

standards for relationships between group health plans and health insurance issuers with enrollees, health professionals, and providers.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the ''Patient Access to Responsible Care Act of 1997''.

(b) TABLE OF CONTENTS.—The table of contents of this Act is as follows:

SEC. 2. PATIENT PROTECTION STANDARDS UNDER THE PUBLIC HEALTH SERVICE ACT.

(a) PATIENT PROTECTION STANDARDS.—Title XXVII of the Public Health Service Act is amended—

(1) by redesignating part C as part D, and

(2) by inserting after part B the following new part:

''PART C—PATIENT PROTECTION STANDARDS

"SEC. 2770. NOTICE; ADDITIONAL DEFINITIONS; CONSTRUCTION.

''(a) NOTICE.—A health insurance issuer under this part shall comply with the notice requirement under section 711(d) of the Employee Retirement Income Security Act of 1974 with respect to the requirements of this part as if such section applied to such issuer and such issuer were a group health plan.

''(b) ADDITIONAL DEFINITIONS.—For purposes of this part:

''(1) ENROLLEE.—The term 'enrollee' means, with respect to health insurance coverage offered by a health insurance issuer, an individual enrolled with the issuer to receive such coverage.

''(2) HEALTH PROFESSIONAL.—The term 'health professional' means a physician or other health care practitioner licensed, accredited, or certified to perform specified health services consistent with State law.

''(3) NETWORK.—The term 'network' means, with respect to a health insurance issuer offering health insurance coverage, the participating health

professionals and providers through whom the plan or issuer provides health care items and services to enrollees.

''(4) NETWORK COVERAGE.—The term 'network coverage' means health insurance coverage offered by a health insurance issuer that provides or arranges for the provision of health care items and services to enrollees through participating health professionals and providers.

''(5) PARTICIPATING.—The term 'participating' means, with respect to a health professional or provider, a health professional or provider that provides health care items and services to enrollees under network coverage under an agreement with the health insurance issuer offering the coverage.

''(6) PRIOR AUTHORIZATION.—The term 'prior authorization' means the process of obtaining prior approval from a health insurance issuer as to the necessity or appropriateness of receiving medical or clinical services for treatment of a medical or clinical condition.

''(7) PROVIDER.—The term 'provider' means a health organization, health facility, or health agency that is licensed, accredited, or certified to provide

health care items and services under applicable State law.

''(8) SERVICE AREA.—The term 'service area' means, with respect to a health insurance issuer with respect to health insurance coverage, the geographic area served by the issuer with respect to the coverage.

''(9) UTILIZATION REVIEW.—The term 'utilization review' means prospective, concurrent, or retrospective review of health care items and services for medical necessity, appropriateness, or quality of care that includes prior authorization requirements for coverage of such items and services.

''(c) NO REQUIREMENT FOR ANY WILLING PROVIDER.—Nothing in this part shall be construed as requiring a health insurance issuer that offers network coverage to include for participation every willing provider or health professional who meets the terms and conditions of the plan or issuer.

''SEC. 2771. ENROLLEE ACCESS TO CARE.

''(a) GENERAL ACCESS.—

''(1) IN GENERAL.—Subject to paragraphs (2), and (3), a health insurance issuer shall establish and maintain adequate arrangements, as defined by the applicable State authority, with a sufficient number,

mix, and distribution of health professionals and providers to assure that covered items and services are available and accessible to each enrollee under health insurance coverage—

"(A) in the service area of the issuer;

"(B) in a variety of sites of service;

"(C) with reasonable promptness (including reasonable hours of operation and after-hours services);

"(D) with reasonable proximity to the residences and workplaces of enrollees; and

"(E) in a manner that—

"(i) takes into account the diverse needs of enrollees, and

"(ii) reasonably assures continuity of care.

For a health insurance issuer that serves a rural or medically underserved area, the issuer shall be treated as meeting the requirement of this subsection if the issuer has arrangements with a sufficient number, mix, and distribution of health professionals and providers having a history of serving such areas. The use of telemedicine and other innovative means to provide covered items and services by a health insurance issuer that serves a rural or medically under-

served area shall also be considered in determining whether the requirement of this subsection is met.

''(2) RULE OF CONSTRUCTION.—Nothing in this subsection shall be construed as requiring a health insurance issuer to have arrangements that conflict with its responsibilities to establish measures designed to maintain quality and control costs.

''(3) DEFINITIONS.—For purposes of paragraph (1):

''(A) MEDICALLY UNDERSERVED AREA.—The term 'medically underserved area' means an area that is designated as a health professional shortage area under section 332 of the Public Health Service Act or as a medically underserved area for purposes of section 330 or 1302(7) of such Act.

''(B) RURAL AREA.—The term 'rural area' means an area that is not within a Standard Metropolitan Statistical Area or a New England County Metropolitan Area (as defined by the Office of Management and Budget).

''(b) EMERGENCY AND URGENT CARE.—

''(1) IN GENERAL.—A health insurance issuer shall—

"(A) assure the availability and accessibility of medically or clinically necessary emergency services and urgent care services within the service area of the issuer 24 hours a day, 7 days a week;

"(B) require no prior authorization for items and services furnished in a hospital emergency department to an enrollee (without regard to whether the health professional or hospital has a contractual or other arrangement with the issuer) with symptoms that would reasonably suggest to a prudent layperson an emergency medical condition (including items and services described in subparagraph (C)(iii));

"(C) cover (and make reasonable payments for)—

"(i) emergency services,

"(ii) services that are not emergency services but are described in subparagraph (B),

"(iii) medical screening examinations and other ancillary services necessary to diagnose, treat, and stabilize an emergency medical condition, and

''(iv) urgent care services, without regard to whether the health professional or provider furnishing such services has a contractual (or other) arrangement with the issuer; and

''(D) make prior authorization determinations for—

''(i) services that are furnished in a hospital emergency department (other than services described in clauses (i) and (iii) of subparagraph (C)), and

''(ii) urgent care services, within the time periods specified in (or pursuant to) section 2776(a)(8).

''(2) DEFINITIONS.—For purposes of this subsection:

''(A) EMERGENCY MEDICAL CONDITION.—The term 'emergency medical condition' means a medical condition (including emergency labor and delivery) manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of

immediate medical attention could reasonably be expected to result in—

"(i) placing the patient's health in serious jeopardy,

"(ii) serious impairment to bodily functions, or

"(iii) serious dysfunction of any bodily organ or part.

"(B) EMERGENCY SERVICES.—The term 'emergency services' means health care items and services that are necessary for the diagnosis, treatment, and stabilization of an emergency medical condition.

"(C) URGENT CARE SERVICES.—The term 'urgent care services' means health care items and services that are necessary for the treatment of a condition that—

"(i) is not an emergency medical condition,

"(ii) requires prompt medical or clinical treatment, and

"(iii) poses a danger to the patient if not treated in a timely manner, as defined by the applicable State authority in con-

sultation with relevant treating health professionals or providers.

''(c) SPECIALIZED SERVICES.—

''(1) IN GENERAL.—A health insurance issuer offering network coverage shall demonstrate that enrollees have access to specialized treatment expertise when such treatment is medically or clinically indicated in the professional judgment of the treating health professional, in consultation with the enrollee.

''(2) DEFINITION.—For purposes of paragraph (1), the term 'specialized treatment expertise' means expertise in diagnosing or treating—

''(A) unusual diseases or conditions, or

''(B) diseases and conditions that are unusually difficult to diagnose or treat.

''(d) INCENTIVE PLANS.—

''(1) IN GENERAL.—In the case of a health insurance issuer that offers network coverage, any health professional or provider incentive plan operated by the issuer with respect to such coverage shall meet the following requirements:

''(A) No specific payment is made directly or indirectly under the plan to a professional or provider or group of professionals or providers as an inducement to reduce or limit medically

necessary services provided with respect to a specific enrollee.

''(B) If the plan places such a professional, provider, or group at substantial financial risk (as determined by the Secretary) for services not provided by the professional, provider, or group, the issuer—

''(i) provides stop-loss protection for the professional, provider, or group that is adequate and appropriate, based on standards developed by the Secretary that take into account the number of professionals or providers placed at such substantial financial risk in the group or under the coverage and the number of individuals enrolled with the issuer who receive services from the professional, provider, or group, and

''(ii) conducts periodic surveys of both individuals enrolled and individuals previously enrolled with the issuer to determine the degree of access of such individuals to services provided by the issuer and satisfaction with the quality of such services.

''(C) The issuer provides the Secretary with descriptive information regarding the plan, sufficient to permit the Secretary to determine whether the plan is in compliance with the requirements of this paragraph.

''(2) In this subsection, the term 'health professional or provider incentive plan' means any compensation arrangement between a health insurance issuer and a health professional or provider or professional or provide group that may directly or indirectly have the effect of reducing or limiting services provided with respect to individuals enrolled with the issuer.

''SEC. 2772. ENROLLEE CHOICE OF HEALTH PROFESSIONALS AND PROVIDERS.

''(a) CHOICE OF PERSONAL HEALTH PROFESSIONAL.—A health insurance issuer shall permit each enrollee under network coverage to—

''(1) select a personal health professional from among the participating health professionals of the issuer, and

''(2) change that selection as appropriate.

''(b) POINT-OF-SERVICE OPTION.—

''(1) IN GENERAL.—If a health insurance issuer offers to enrollees health insurance coverage which

provides for coverage of services only if such services are furnished through health professionals and providers who are members of a network of health professionals and providers who have entered into a contract with the issuer to provide such services, the issuer shall also offer to such enrollees (at the time of enrollment) the option of health insurance coverage which provides for coverage of such services which are not furnished through health professionals and providers who are members of such a network.

''(2) FAIR PREMIUMS.—The amount of any additional premium required for the option described in paragraph (1) may not exceed an amount that is fair and reasonable, as established by the applicable State authority, in consultation with the National Association of Insurance Commissioners, based on the nature of the additional coverage provided.

''(3) COST-SHARING.—Under the option described in paragraph (1), the health insurance coverage shall provide for reimbursement rates for covered services offered by health professionals and providers who are not participating health professionals or providers that are not less than the reimbursement rates for covered services offered by participating health professionals and providers. Nothing in

this paragraph shall be construed as protecting an enrollee against balance billing by a health professional or provider that is not a participating health professional or provider.

''(c) CONTINUITY OF CARE.—A health insurance issuer offering network coverage shall—

''(1) ensure that any process established by the issuer to coordinate care and control costs does not create an undue burden, as defined by the applicable State authority, for enrollees with special health care needs or chronic conditions;

''(2) ensure direct access to relevant specialists for the continued care of such enrollees when medically or clinically indicated in the judgment of the treating health professional, in consultation with the enrollee;

''(3) in the case of an enrollee with special health care needs or a chronic condition, determine whether, based on the judgment of the treating health professional, in consultation with the enrollee, it is medically or clinically necessary to use a specialist or a care coordinator from an interdisciplinary team to ensure continuity of care; and

''(4) in circumstances under which a change of health professional or provider might disrupt the continuity of care for an enrollee, such as—

''(A) hospitalization, or

''(B) dependency on high-technology home medical equipment,

provide for continued coverage of items and services furnished by the health professional or provider that was treating the enrollee before such change for a reasonable period of time.

For purposes of paragraph (4), a change of health professional or provider may be due to changes in the membership of an issuer's health professional and provider network, changes in the health coverage made available by an employer, or other similar circumstances.

"SEC. 2773. NONDISCRIMINATION AGAINST ENROLLEES AND IN THE SELECTION OF HEALTH PROFESSIONALS; EQUITABLE ACCESS TO NETWORKS.

''(a) NONDISCRIMINATION AGAINST ENROLLEES.—No health insurance issuer may discriminate (directly or through contractual arrangements) in any activity that has the effect of discriminating against an individual on the basis of race, national origin, gender, language, socioeconomic status, age, disability, health status, or anticipated need for health services.

''(b) NONDISCRIMINATION IN SELECTION OF NETWORK HEALTH PROFESSIONALS.—A health insurance issuer offering network coverage shall not discriminate in selecting the members of its health professional network (or in establishing the terms and conditions for membership in such network) on the basis of—

''(1) the race, national origin, gender, age, or disability (other than a disability that impairs the ability of an individual to provide health care services or that may threaten the health of enrollees) of the health professional; or

''(2) the health professional's lack of affiliation with, or admitting privileges at, a hospital (unless such lack of affiliation is a result of infractions of quality standards and is not due to a health professional's type of license).

''(c) NONDISCRIMINATION IN ACCESS TO HEALTH PLANS.—While nothing in this section shall be construed as an 'any willing provider' requirement (as referred to in section 2770(c)), a health insurance issuer shall not discriminate in participation, reimbursement, or indemnification against a health professional, who is acting within the scope of the health professional's license or certification under applicable State law, solely on the basis of such license or certification.

"SEC. 2774. PROHIBITION OF INTERFERENCE WITH CERTAIN MEDICAL COMMUNICATIONS.

''(a) IN GENERAL.—The provisions of any contract or agreement, or the operation of any contract or agreement, between a health insurance issuer and a health professional shall not prohibit or restrict the health professional from engaging in medical communications with his or her patient.

''(b) NULLIFICATION.—Any contract provision or agreement described in subsection (a) shall be null and void.

''(c) MEDICAL COMMUNICATION DEFINED.—For purposes of this section, the term 'medical communication' means a communication made by a health professional with a patient of the health professional (or the guardian or legal representative of the patient) with respect to—

''(1) the patient's health status, medical care, or legal treatment options;

''(2) any utilization review requirements that may affect treatment options for the patient; or

''(3) any financial incentives that may affect the treatment of the patient.

"SEC. 2775. DEVELOPMENT OF PLAN POLICIES.

''A health insurance issuer that offers network coverage shall establish mechanisms to consider the recommendations, suggestions, and views of enrollees and

participating health professionals and providers regarding—

''(1) the medical policies of the issuer (including policies relating to coverage of new technologies, treatments, and procedures);

''(2) the utilization review criteria and procedures of the issuer;

''(3) the quality and credentialing criteria of the issuer; and

''(4) the medical management procedures of the issuer.

''SEC. 2776. DUE PROCESS FOR ENROLLEES.

''(a) UTILIZATION REVIEW.—The utilization review program of a health insurance issuer shall—

''(1) be developed (including any screening criteria used by such program) with the involvement of participating health professionals and providers;

''(2) to the extent consistent with the protection of proprietary business information (as defined for purposes of section 552 of title 5, United States Code) release, upon request, to affected health professionals, providers, and enrollees the screening criteria, weighting elements, and computer algorithms used in reviews and a description of the method by which they were developed;

''(3) uniformly apply review criteria that are based on sound scientific principles and the most recent medical evidence;

''(4) use licensed, accredited, or certified health professionals to make review determinations (and for services requiring specialized training for their delivery, use a health professional who is qualified through equivalent specialized training and experience);

''(5) subject to reasonable safeguards, disclose to health professionals and providers, upon request, the names and credentials of individuals conducting utilization review;

''(6) not compensate individuals conducting utilization review for denials of payment or coverage of benefits;

''(7) comply with the requirement of section 2771 that prior authorization not be required for emergency and related services furnished in a hospital emergency department;

''(8) make prior authorization determinations—

''(A) in the case of services that are urgent care services described in section 2771(b)(2)(C), within 30 minutes of a request for such determination, and

''(B) in the case of other services, within 24 hours after the time of a request for determination;

''(9) include in any notice of such determination an explanation of the basis of the determination and the right to an immediate appeal;

''(10) treat a favorable prior authorization review determination as a final determination for purposes of making payment for a claim submitted for the item or service involved unless such determination was based on false information knowingly supplied by the person requesting the determination;

''(11) provide timely access, as defined by the applicable State authority, to utilization review personnel and, if such personnel are not available, waives any prior authorization that would otherwise be required; and

''(12) provide notice of an initial determination on payment of a claim within 30 days after the date the claim is submitted for such item or service, and include in such notice an explanation of the reasons for such determination and of the right to an immediate appeal.

''(b) APPEALS PROCESS.—A health insurance issuer shall establish and maintain an accessible appeals process that—

''(1) reviews an adverse prior authorization determination—

''(A) for urgent care services, described in subsection (a)(8)(A), within 1 hour after the time of a request for such review, and

''(B) for other services, within 24 hours after the time of a request for such review;

''(2) reviews an initial determination on payment of claims described in subsection (a)(12) within 30 days after the date of a request for such review;

''(3) provides for review of determinations described in paragraphs (1) and (2) by an appropriate clinical peer professional who is in the same or similar specialty as would typically provide the item or service involved (or another licensed, accredited, or certified health professional acceptable to the plan and the person requesting such review); and

''(4) provides for review of—

''(A) the determinations described in paragraphs (1), (2), and (3), and

''(B) enrollee complaints about inadequate access to any category or type of health professional or provider in the network of the issuer or other matters specified by this part,

by an appropriate clinical peer professional who is in the same or similar specialty as would typically provide the item or service involved (or another licensed, accredited, or certified health professional acceptable to the issuer and the person requesting such review) that is not involved in the operation of the plan or in making the determination or policy being appealed.

The procedures specified in this subsection shall not be construed as preempting or superseding any other reviews or appeals an issuer is required by law to make available.

''SEC. 2777. DUE PROCESS FOR HEALTH PROFESSIONALS AND PROVIDERS.

''(a) IN GENERAL.—A health insurance issuer with respect to its offering of network coverage shall—

''(1) allow all health professionals and providers in its service area to apply to become a participating health professional or provider during at least one period in each calendar year;

''(2) provide reasonable notice to such health professionals and providers of the opportunity to

apply and of the period during which applications are accepted;

''(3) provide for review of each application by a credentialing committee with appropriate representation of the category or type of health professional or provider;

''(4) select participating health professionals and providers based on objective standards of quality developed with the suggestions and advice of professional associations, health professionals, and providers;

''(5) make such selection standards available to—

''(A) those applying to become a participating provider or health professional;

''(B) health plan purchasers, and

''(C) enrollees;

''(6) when economic considerations are taken into account in selecting participating health professionals and providers, use objective criteria that are available to those applying to become a participating provider or health professional and enrollees;

''(7) adjust any economic profiling to take into account patient characteristics (such as severity of

illness) that may result in atypical utilization of services;

''(8) make the results of such profiling available to insurance purchasers, enrollees, and the health professional or provider involved;

''(9) notify any health professional or provider being reviewed under the process referred to in paragraph (3) of any information indicating that the health professional or provider fails to meet the standards of the issuer;

''(10) offer a health professional or provider receiving notice pursuant to the requirement of paragraph (9) with an opportunity to—

''(A) review the information referred to in such paragraph, and

''(B) submit supplemental or corrected information;

''(11) not include in its contracts with participating health professionals and providers a provision permitting the issuer to terminate the contract 'without cause';

''(12) provide a due process appeal that conforms to the process specified in section 412 of the Health Care Quality Improvement Act of 1986 (42

U.S.C. 11112) for all determinations that are adverse to a health professional or provider; and

"(13) unless a health professional or provider poses an imminent harm to enrollees or an adverse action by a governmental agency effectively impairs the ability to provide health care items and services, provide—

"(A) reasonable notice of any decision to terminate a health professional or provider 'for cause' (including an explanation of the reasons for the determination),

"(B) an opportunity to review and discuss all of the information on which the determination is based, and

"(C) an opportunity to enter into a corrective action plan, before the determination becomes subject to appeal under the process referred to in paragraph (12).

"(b) RULE OF CONSTRUCTION.—The requirements of subsection (a) shall not be construed as preempting or superseding any other reviews and appeals a health insurance issuer is required by law to make available.

"SEC. 2778. INFORMATION REPORTING AND DISCLOSURE.

''(a) IN GENERAL.—A health insurance issuer offering health insurance coverage shall provide enrollees and prospective enrollees with information about—

''(1) coverage provisions, benefits, and any exclusions—

''(A) by category of service,

''(B) by category or type of health professional or provider, and

''(C) if applicable, by specific service, including experimental treatments;

''(2) the percentage of the premium charged by the issuer that is set aside for administration and marketing of the issuer;

''(3) the percentage of the premium charged by the issuer that is expended directly for patient care;

''(4) the number, mix, and distribution of participating health professionals and providers;

''(5) the ratio of enrollees to participating health professionals and providers by category and type of health professional and provider;

''(6) the expenditures and utilization per enrollee by category and type of health professional and provider;

''(7) the financial obligations of the enrollee and the issuer, including premiums, copayments,

deductibles, and established aggregate maximums on out-of-pocket costs, for all items and services, including—

"(A) those furnished by health professionals and providers that are not participating health professionals and providers, and

"(B) those furnished to an enrollee who is outside the service area of the coverage;

"(8) utilization review requirements of the issuer (including prior authorization review, concurrent review, post-service review, post-payment review, and any other procedures that may lead to denial of coverage or payment for a service);

"(9) financial arrangements and incentives that may—

"(A) limit the items and services furnished to an enrollee,

"(B) restrict referral or treatment options, or

"(C) negatively affect the fiduciary responsibility of a health professional or provider to an enrollee;

"(10) other incentives for health professionals and providers to deny or limit needed items or services;

''(11) quality indicators for the issuer and participating health professionals and providers, including performance measures such as appropriate referrals and prevention of secondary complications following treatment;

''(12) grievance procedures and appeals rights under the coverage, and summary information about the number and disposition of grievances and appeals in the most recent period for which complete and accurate information is available; and

''(13) the percentage of utilization review determinations made by the issuer that disagree with the judgment of the treating health professional or provider and the percentage of such determinations that are reversed on appeal.

''(b) REGULATIONS.—The Secretary, in collaboration with the Secretary of Labor, shall issue regulations to establish—

''(1) the styles and sizes of type to be used with respect to the appearance of the publication of the information required under subsection (a);

''(2) standards for the publication of information to ensure that such publication is—

''(A) readily accessible, and

''(B) in common language easily understood,

by individuals with little or no connection to or understanding of the language employed by health professionals and providers, health insurance issuers, or other entities involved in the payment or delivery of health care services, and

''(3) the placement and positioning of information in health plan marketing materials.

"SEC. 2779. CONFIDENTIALITY; ADEQUATE RESERVES.

''(a) CONFIDENTIALITY.—

''(1) IN GENERAL.—A health insurance issuer shall establish mechanisms and procedures to ensure compliance with applicable Federal and State laws to protect the confidentiality of individually identifiable information held by the issuer with respect to an enrollee, health professional, or provider.

''(2) DEFINITION.—For purposes of paragraph (1), the term 'individually identifiable information' means, with respect to an enrollee, a health professional, or a provider, any information, whether oral or recorded in any medium or form, that identifies or can readily be associated with the identity of the enrollee, the health professional, or the provider.

''(b) FINANCIAL RESERVES; SOLVENCY.—A health insurance issuer shall—

''(1) meet such financial reserve or other solvency-related requirements as the applicable State authority may establish to assure the continued availability of (and appropriate payment for) covered items and services for enrollees; and

''(2) establish mechanisms specified by the applicable State authority to protect enrollees, health professionals, and providers in the event of failure of the issuer.

Such requirements shall not unduly impede the establishment of health insurance issuers owned and operated by health care professionals or providers or by non-profit community-based organizations.

''SEC. 2780. QUALITY IMPROVEMENT PROGRAM.

''(a) IN GENERAL.—A health insurance issuer shall establish a quality improvement program (consistent with subsection (b)) that systematically and continuously assesses and improves—

''(1) enrollee health status, patient outcomes, processes of care, and enrollee satisfaction associated with health care provided by the issuer; and

''(2) the administrative and funding capacity of the issuer to support and emphasize preventive care,

utilization, access and availability, cost effectiveness, acceptable treatment modalities, specialists referrals, the peer review process, and the efficiency of the administrative process.

''(b) FUNCTIONS.—A quality improvement program established pursuant to subsection (a) shall—

''(1) assess the performance of the issuer and its participating health professionals and providers and report the results of such assessment to purchasers, participating health professionals and providers, and administrative personnel;

''(2) demonstrate measurable improvements in clinical outcomes and plan performance measured by identified criteria, including those specified in subsection (a)(1); and

''(3) analyze quality assessment data to determine specific interactions in the delivery system (both the design and funding of the health insurance coverage and the clinical provision of care) that have an adverse impact on the quality of care.''.

(b) APPLICATION TO GROUP HEALTH INSURANCE COVERAGE.—

(1) Subpart 2 of part A of title XXVII of the Public Health Service Act is amended by adding at the end the following new section:

"SEC. 2706. PATIENT PROTECTION STANDARDS.

"(a) IN GENERAL.—Each health insurance issuer shall comply with patient protection requirements under part C with respect to group health insurance coverage it offers.

"(b) ASSURING COORDINATION.—The Secretary of Health and Human Services and the Secretary of Labor shall ensure, through the execution of an interagency memorandum of understanding between such Secretaries, that—

"(1) regulations, rulings, and interpretations issued by such Secretaries relating to the same matter over which such Secretaries have responsibility under part C (and this section) and section 713 of the Employee Retirement Income Security Act of 1974 are administered so as to have the same effect at all times; and

"(2) coordination of policies relating to enforcing the same requirements through such Secretaries in order to have a coordinated enforcement strategy that avoids duplication of enforcement efforts and assigns priorities in enforcement.".

(2) Section 2792 of such Act (42 U.S.C. 300gg–92) is amended by inserting "and section 2706(b)" after "of 1996".

(c) APPLICATION TO INDIVIDUAL HEALTH INSURANCE COVERAGE.—Part B of title XXVII of the Public Health Service Act is amended by inserting after section 2751 the following new section:

"SEC. 2752. PATIENT PROTECTION STANDARDS.

"Each health insurance issuer shall comply with patient protection requirements under part C with respect to individual health insurance coverage it offers.".

(d) MODIFICATION OF PREEMPTION STANDARDS.—

(1) GROUP HEALTH INSURANCE COVERAGE.—Section 2723 of such Act (42 U.S.C. 300gg–23) is amended—

(A) in subsection (a)(1), by striking "subsection (b)" and inserting "subsections (b) and (c)";

(B) by redesignating subsections (c) and (d) as subsections (d) and (e), respectively; and

(C) by inserting after subsection (b) the following new subsection:

"(c) SPECIAL RULES IN CASE OF PATIENT PROTECTION REQUIREMENTS.—Subject to subsection (a)(2), the provisions of section 2706 and part C, and part D insofar as it applies to section 2706 or part C, shall not be construed to preempt any State law, or the enactment or implementation of such a State law, that provides protections

for individuals that are equivalent to or stricter than the protections provided under such provisions.''.

(2) INDIVIDUAL HEALTH INSURANCE COVERAGE.—Section 2762 of such Act (42 U.S.C. 300gg–62), as added by section 605(b)(3)(B) of Public Law 104–204, is amended—

(A) in subsection (a), by striking ''subsection (b), nothing in this part'' and inserting ''subsections (b) and (c)'', and

(B) by adding at the end the following new subsection:

''(c) SPECIAL RULES IN CASE OF PATIENT PROTECTION REQUIREMENTS.—Subject to subsection (b), the provisions of section 2752 and part C, and part D insofar as it applies to section 2752 or part C, shall not be construed to preempt any State law, or the enactment or implementation of such a State law, that provides protections for individuals that are equivalent to or stricter than the protections provided under such provisions.''.

(e) ADDITIONAL CONFORMING AMENDMENTS.—

(1) Section 2723(a)(1) of such Act (42 U.S.C. 300gg–23(a)(1)) is amended by striking ''part C'' and inserting ''parts C and D''.

(2) Section 2762(b)(1) of such Act (42 U.S.C. 300gg–62(b)(1)) is amended by striking ''part C'' and inserting ''part D''.

(f) EFFECTIVE DATES.—(1)(A) Subject to subparagraph (B), the amendments made by subsections (a), (b), (d)(1), and (e) shall apply with respect to group health insurance coverage for group health plan years beginning on or after July 1, 1998 (in this subsection referred to as the ''general effective date'') and also shall apply to portions of plan years occurring on and after January 1, 1999.

(B) In the case of group health insurance coverage provided pursuant to a group health plan maintained pursuant to 1 or more collective bargaining agreements between employee representatives and 1 or more employers ratified before the date of enactment of this Act, the amendments made by subsections (a), (b), (d)(1), and (e) shall not apply to plan years beginning before the later of—

(i) the date on which the last collective bargaining agreements relating to the plan terminates (determined without regard to any extension thereof agreed to after the date of enactment of this Act), or

(ii) the general effective date.

For purposes of clause (i), any plan amendment made pursuant to a collective bargaining agreement relating to the plan which amends the plan solely to conform to any requirement added by subsection (a) or (b) shall not be treated as a termination of such collective bargaining agreement.

(2) The amendments made by subsections (a), (c), (d)(2), and (e) shall apply with respect to individual health insurance coverage offered, sold, issued, renewed, in effect, or operated in the individual market on or after the general effective date.

SEC. 3. PATIENT PROTECTION STANDARDS UNDER THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974.

(a) IN GENERAL.—Subpart B of part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 is amended by adding at the end the following new section:

"SEC. 713. PATIENT PROTECTION STANDARDS.

''(a) IN GENERAL.—Subject to subsection (b), a group health plan (and a health insurance issuer offering group health insurance coverage in connection with such a plan) shall comply with the requirements of part C of title XXVII of the Public Health Service Act.

''(b) REFERENCES IN APPLICATION.—In applying subsection (a) under this part, any reference in such part C—

''(1) to a health insurance issuer and health insurance coverage offered by such an issuer is deemed to include a reference to a group health plan and coverage under such plan, respectively;

''(2) to the Secretary is deemed a reference to the Secretary of Labor;

''(3) to an applicable State authority is deemed a reference to the Secretary of Labor; and

''(4) to an enrollee with respect to health insurance coverage is deemed to include a reference to a participant or beneficiary with respect to a group health plan.

''(c) ASSURING COORDINATION.—The Secretary of Health and Human Services and the Secretary of Labor shall ensure, through the execution of an interagency memorandum of understanding between such Secretaries, that—

''(1) regulations, rulings, and interpretations issued by such Secretaries relating to the same matter over which such Secretaries have responsibility under such part C (and section 2706 of the Public

Health Service Act) and this section are administered so as to have the same effect at all times; and

''(2) coordination of policies relating to enforcing the same requirements through such Secretaries in order to have a coordinated enforcement strategy that avoids duplication of enforcement efforts and assigns priorities in enforcement.''.

(b) MODIFICATION OF PREEMPTION STANDARDS.—Section 731 of such Act (42 U.S.C. 1191) is amended—

(1) in subsection (a)(1), by striking ''subsection (b)'' and inserting ''subsections (b) and (c)'';

(2) by redesignating subsections (c) and (d) as subsections (d) and (e), respectively; and

(3) by inserting after subsection (b) the following new subsection:

''(c) SPECIAL RULES IN CASE OF PATIENT PROTECTION REQUIREMENTS.—Subject to subsection (a)(2), the provisions of section 713 and part C of title XXVII of the Public Health Service Act, and subpart C insofar as it applies to section 713 or such part, shall not be construed to preempt any State law, or the enactment or implementation of such a State law, that provides protections for individuals that are equivalent to or stricter than the protections provided under such provisions.''.

(c) CONFORMING AMENDMENTS.— (1) Section 732(a) of such Act (29 U.S.C. 1185(a)) is amended by striking ''section 711'' and inserting ''sections 711 and 713''.

(2) The table of contents in section 1 of such Act is amended by inserting after the item relating to section 712 the following new item:

''Sec. 713. Patient protection standards.''.

(3) Section 734 of such Act (29 U.S.C. 1187) is amended by inserting ''and section 713(d)'' after ''of 1996''.

(d) EFFECTIVE DATE.—(1) Subject to paragraph (2), the amendments made by this section shall apply with respect to group health plans for plan years beginning on or after July 1, 1998 (in this subsection referred to as the ''general effective date'') and also shall apply to portions of plan years occurring on and after January 1, 1999.

(2) In the case of a group health plan maintained pursuant to 1 or more collective bargaining agreements between employee representatives and 1 or more employers ratified before the date of enactment of this Act, the amendments made by this section shall not apply to plan years beginning before the later of—

(A) the date on which the last collective bargaining agreements relating to the plan terminates

(determined without regard to any extension thereof agreed to after the date of enactment of this Act), or

(B) the general effective date.

For purposes of subparagraph (A), any plan amendment made pursuant to a collective bargaining agreement relating to the plan which amends the plan solely to conform to any requirement added by subsection (a) shall not be treated as a termination of such collective bargaining agreement.

SEC. 4. NON-PREEMPTION OF STATE LAW RESPECTING LIABILITY OF GROUP HEALTH PLANS.

(a) IN GENERAL.—Section 514(b) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1144(b)) is amended by redesignating paragraph (9) as paragraph (10) and inserting the following new paragraph:

''(9) Subsection (a) of this section shall not be construed to preclude any State cause of action to recover damages for personal injury or wrongful death against any person that provides insurance or administrative services to or for an employee welfare benefit plan maintained to provide health care benefits.''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to causes of action arising on or after the date of the enactment of this Act.

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